FOR OHF USE

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2001

STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2001)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0021	501		II. CERTIF	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: LINCOLN MANOR INC. Address: 2650 NORTH MONROE Number County: MACON	DECATUR City	62526 Zip Code	State of and cert are true,	e examined the contents of the accompanying report to the Illinois, for the period from 01/01/01 to 12/31/01 ify to the best of my knowledge and belief that the said contents accurate and complete statements in accordance with ole instructions. Declaration of preparer (other than provider)
	Telephone Number: (217) 875-1973 IDPA ID Number: 370915183001	Fax # (217) 875-2172		Intent	on all information of which preparer has any knowledge. tional misrepresentation or falsification of any information ost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: Type of Ownership:	04/21/75		Officer or	(Signed)(Date) (Type or Print Name)
	VOLUNTARY,NON-PROFIT Charitable Corp. Trust	X PROPRIETARY Individual Partnership	GOVERNMENTAL State County		(Title) (Signed) See Accountants' Compilation Report Attached
	IRS Exemption Code	Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Preparer	(Print Name and Title) (Firm Name Frost, Ruttenberg & Rothblatt, P.C.
	In the event there are further questions about to Name: Steve Lavenda	his report, please contact: Telephone Number: (847) 236	- 1111		& Address) 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax# (847) 236-1155 MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS

Facil	ity Name & ID Numb	oer LINCOLN M	IANOR INC.				# 0021501 Report Period Beginning: 01/01/01 Ending: 12/31/01
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	f care; enter numbei	of beds/bed days,			103 (Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds			
	, 0		J				E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes
	Report Period	Level of C		Report Period	Report Period		1. Does the facility maintain a daily manight census.
	Report 1 criou	Level of	care	Report Feriou	Report 1 eriou		G. Do pages 3 & 4 include expenses for services or
1	24	Skilled (SNI	7)	24	8,760	1	investments not directly related to patient care?
2	24		atric (SNF/PED)	24	0,700	2	YES NO X
3	116	Intermediat		116	42,340	3	TES NO A
4	110	Intermediat		110	42,540	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered Ca				5	YES NO X
6		ICF/DD 16 o				6	TES NO A
-		ICI7DD 10	JI Less			+	I. On what date did you start providing long term care at this location?
7	140	TOTALS		140	51,100	7	Date started 04/01/75
				•	,		
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	iod.				YES Date NO X
	1	2	3	4	5		<u> </u>
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid	Į.				YES NO X If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8	SNF	740	908		1,648	8	
9	SNF/PED					9	Medicare Intermediary
10	ICF	25,616	18,845		44,461	10	•
11	ICF/DD	,	· ·			11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	26,356	19,753		46,109	14	Is your fiscal year identical to your tax year? YES X NO
		,	,	•	,		
		cupancy. (Column 5,		tal licensed			Tax Year: 12/31/01 Fiscal Year: 12/31/01
	bed days or	n line 7, column 4.)	90.23%	_			* All facilities other than governmental must report on the accrual basis.

LINCOLN MANOR INC. 0021501 **Report Period Beginning:** 01/01/01 12/31/01 **Facility Name & ID Number** Ending: V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) Costs Per General Ledger Reclass-Reclassified Adjust-Adjusted FOR OHF USE ONLY Salary/Wage Supplies ification **Operating Expenses** Other Total Total ments Total A. General Services 2 3 4 5 6 7 8 10 273,960 273,960 273,960 Dietary 234,234 24,370 15,356 215,912 215,912 214,987 Food Purchase 215,912 (925)2 163,678 163,678 163,678 Housekeeping 148,458 14,416 804 3 14,570 3,534 85,277 85,277 85,277 Laundry 67,173 4 97,813 97,813 Heat and Other Utilities 97,813 97,813 5 52,222 137,515 137,515 (40.351)97,164 Maintenance 3,108 82,185 6 Other (specify):* **TOTAL General Services** 502,087 272,376 199,692 974,155 974,155 (41,276) 932,879 B. Health Care and Programs Medical Director 13,950 13,950 13,950 13,950 27,574 Nursing and Medical Records 1,245,920 1,301,969 1,301,969 1,301,969 28,475 10 10a Therapy 100 100 100 100 10a 106,350 Activities 97,003 4,660 106,435 106,435 (85) 11 4,772 11 35,025 35,025 35,025 Social Services 34,486 539 12 Nurse Aide Training 13 Program Transportation 1,193 1,193 1,193 1,193 14 Other (specify):* 15 1.377,409 1,458,672 1,458,587 TOTAL Health Care and Programs 33,786 47,477 1,458,672 (85)16 C. General Administration 17 Administrative 100,000 100,000 100,000 100,000 17 Directors Fees 16,800 16,800 16,800 16,800 18 41,010 41,010 359 41,369 Professional Services 41,010 19 Dues, Fees, Subscriptions & Promotions 9,619 3,803 9,619 9,619 (5,816)20 21 Clerical & General Office Expenses 52,517 13,897 20,511 86,925 86,925 (14,516) 72,409 21 Employee Benefits & Payroll Taxes 356,961 356,961 324,161 356,961 (32,800)22 Inservice Training & Education 23 Travel and Seminar 5,748 5,748 5,748 (900)4,848 24 Other Admin. Staff Transportation 239 239 239 239 25 Insurance-Prop.Liab.Malpractice 68,002 68,002 68,002 26 68,002 27 Other (specify):* 27 **TOTAL General Administration** 13.897 685,304 631,631 28 152,517 518,890 685,304 (53.673)TOTAL Operating Expense 2,032,013 320,059 766,059 3,118,131 3,118,131 (95,034)3,023,097 29 (sum of lines 8, 16 & 28)

STATE OF ILLINOIS

Page 3

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Report Period Beginning:

V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			98,565	98,565		98,565	(43,487)	55,078			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			39,750	39,750		39,750		39,750			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,406	4,406		4,406		4,406			35
36	Other (specify):*											36
37	TOTAL Ownership			142,721	142,721		142,721	(43,487)	99,234			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	9,771			9,771		9,771		9,771			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):*			966	966		966	(966)				43
44	TOTAL Special Cost Centers	9,771		77,616	87,387		87,387	(966)	86,421			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,041,784	320,059	986,396	3,348,239		3,348,239	(139,487)	3,208,752			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Report Period Beginning:

01/01/01

Ending:

Page 5 12/31/01

4

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Th Column	l 2 Delow,	1	2	articular 3	ai cosi
	NON-ALLOWABLE EXPENSES		Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$	Timount	cnee	\$	1
2	Other Care for Outpatients	-			1	2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		(43,487)	30		9
10	Interest and Other Investment Income		() /			10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(925)	02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(347)	21		18
19	Entertainment					19
20	Contributions		(200)	20		20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional		(663)	20		25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax					26
27						27
28	Yellow Page Advertising		(903)	20		28
29	Other-Attach Schedule		(92,962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(139,487)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	<u> </u>	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (139,487)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

1 2 3

(50	c mon actions.		_		-	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STAT	E OF ILLINOIS		Page 5A
LINCOLN MANOR INC.			
ID#	0021501		
Report Period Beginning:	01/01/01		
Ending:	12/31/01		
			Sch. V Line
NON-ALLOWABLE EXI	PENSES	Amount	Reference

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Capitalized Repairs & Maintenance	\$ (40,351)	6	1
2	RESIDENTS GIFTS	(85)	- 11	2
3	PUBLIC RELATIONS MISC. ADMINISTRATIVE	(4,050)	20	3
4	ACCRUED LEGAL EXPENSE	(2,837) 1,635	21 19	5
6	FRANCHISE TAXES	(100)	21	6
7	NURSES HOME TAX	(966)	43	7
8	STATE INCOME TAXES	(11,232)	21	8
9	ACCRUED ACCOUNTING EXP.	124	19	9
10	ADM RETIREMENT FUND	(32,800)	22	10
11	OUT OF STATE TRAVEL	(900)	24	11
12	REVERSE PY ACCOUNTING ACCRUAL	(1,400)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
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24 25				24 25
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30		1		30
31		1		31
32				32
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79				79
80				80
81				81
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85				85
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89				89
90	i e	1		90

11/7/2005 3:17 PM

STATE OF ILLINOIS

Summary A Facility Name & ID Number LINCOLN MANOR INC. # 0021501 Report Period Beginning: 01/01/01 **Ending:** 12/31/01 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6 C	6 D	6E	6F	6G	6Н	6 I	(to Sch V, col.	.7)
1	Dietary													1
2	Food Purchase	(925)											(925)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(40,351)											(40,351)	6
7	Other (specify):*													7
8	TOTAL General Services	(41,276)											(41,276)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	1 5													10a
11	Activities	(85)											(85)	
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(85)											(85)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	359											359	19
20	Fees, Subscriptions & Promotions	(5,816)											(/ /	
21	Clerical & General Office Expenses	(14,516)											(/ /	
22	Employee Benefits & Payroll Taxes	(32,800)											(32,800)	
23	Inservice Training & Education													23
24	Travel and Seminar	(900)											(900)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(53,673)											(53,673)	28
	TOTAL Operating Expense													1 1
29	(sum of lines 8,16 & 28)	(95,034)											(95,034)	29

LINCOLN MANOR INC.

0021501

Report Period Beginning:

01/01/01 Ending:

Summary B 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col.	
30	Depreciation	(43,487)											(43,487)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest													32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(43,487)											(43,487)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(966)											(966)	43
44	TOTAL Special Cost Centers	(966)											(966)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(139,487)											(139,487)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

		organizations (parties) as asimoa in the metractions. Attach an additional constant in hoosestry.							
		2	3						
RS	RELATED NURSING HOMES			OTHER RELATED BUSINESS ENTITIES					
Ownership %	Name	City		Name	City	Type of Business			
	NONE		1	NONE					
	RS	RS RELATION Name	RS RELATED NURSING HOMES Ownership % Name City	2 RS RELATED NURSING HOMES Ownership % Name City	2 RELATED NURSING HOMES Ownership % Name City Name	2 RELATED NURSING HOMES Ownership % Name City Name City Same City Name City			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					-	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					-	Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V							_	12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

01/01/01

VII. RELATED PARTIES (continued)

3.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes rent,
	management fees, nurchase of supplies, and so forth		VES	X	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	\neg
1	2	5 Cost l'el Gellel al Leugel	4	S Cost to Related Of gailization		1		
					Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					Ownership	Organization	Costs (7 minus 4)	
15 V			\$			\$	\$ 1	15
16 V							1	16
17 V								17
18 V							1	18
19 V								19
20 V								20
21 V							2	21
22 V							2	22
23 V								23
24 V							2	24
25 V							2	25
26 V		_					2	26
27 V								27
28 V								28
29 V							2	29
30 V							3	30
31 V							3	31
32 V		_					3	32
33 V		_					3	33
34 V							3	34
35 V		_					3	35
36 V							3	36
37 V							3	37
38 V								38
39 Total			\$			\$	\$ * 3	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

LINCOLN MANOR INC.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

_	the msu t		or determining costs as specified for	ı	T	1	ı	ı	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	,
2011		2,110	200	12	Time of Itemore organization	Ownership	Organization	Costs (7 minus 4)	_
15	V			S		Ownership	S Organization	costs (7 mmus 4)	15
16	V			3			3	3	16
17	V	-				+			17
18	V	-				+			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
	Total			e			c	\$ *	39
39	Total			Þ			Þ	Φ	37

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

0021501

01/01/01

VII. RELATED PARTIES (continued)

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o wheremp	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

VII. RELATED PARTIES	(continued)
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B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					Ownership		Costs (7 minus 4)	
15 V			\$			\$		15
16 V								16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V								34
35 V								35
36 V								36
37 V								37
38 V					<u> </u>			38
39 Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

		STATE OF ILLINOIS				1	Page 6E
Facility Name & ID Number	LINCOLN MANOR INC.		021501	Report Period Beginning:	01/01/01	Ending:	12/31/01

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

tile	the instructions for determining costs as specified for this form.								
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
							Operating Cost	Adjustments for	
Schedul	le V	Line	Item	Amount	Name of Related Organization	Percent of	of Related	Related Organization	
Schedu	10 ,	Zine	10011	Timount	Tume of Related Organization				•
15	V			Φ.		Ownership	Organization	Costs (7 minus 4)	15
15	V			3			\$	3	15
16	V								16
17	V								17
18	V								18
19	V								19 20
20	V								20
	V								22
22	V								23
	V								
24	•								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	•								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39 To	tal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

VII. RELATED PARTIES (continued)

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

tile	the instructions for determining costs as specified for this form.								
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
							Operating Cost	Adjustments for	
Schedul	le V	Line	Item	Amount	Name of Related Organization	Percent of	of Related	Related Organization	
Schedu	10 ,	Zine	10011	Timount	Tume of Related Organization				•
15	V			Φ.		Ownership	Organization	Costs (7 minus 4)	15
15	V			3			\$	3	15
16	V								16
17	V								17
18	V								18
19	V								19 20
20	V								20
	V								22
22	V								23
	V								
24	•								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	•								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39 To	tal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

LINCOLN MANOR INC.	#	0021501	Report Period Beginning:	01/01/01	Ending:	12/31/0
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VII. RELATED PARTIES (continued)

Facility Name & ID Number

B.	Are any costs included in this report which are a result of transactions with	h relat	ted organizati	ons?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization		of Related	Related Organization	
						Organization	Costs (7 minus 4)	
15 V			\$		1	\$		15
16 V								16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32								32
33 V								33
34 V								34
35 V								35
30 Y								36
37 V					<u> </u>			37
36 V								38
39 Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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LINCOLN MANOR INC.	#	0021501	Report Period Begins	ning:	01/01/01	Ending:	12/31/0	1

VII. RELATED PARTIES (continued)

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
			20022		- ···· ·- · · · · · · · · · · · · · ·	Ownership	Organization	Costs (7 minus 4)	
15	V			S		O WHEI SHIP	S		15
16	V			Ψ					16
17	V								17
18	V								18
19	V								19
20	V								20
21	V							2	21
22	V								22
23	V								23
24	V								24
25	V							2	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V							3	32
33	V								33
34	V								34
35	V							3	35
36	V								36
37	V							3	37
38	V							3	38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6		7		
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensation	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	Column		
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	MORTON MELNIK	DIRECTOR	ADMIN	10.00%	NONE	9	25.71%	DIR. FEES	\$ 2,000	18-3	1
2	GERSHON COHN	DIRECTOR	ADMIN	6.00%	NONE	5	14.29%	DIR. FEES	3,000	18-3	2
3	CARL WEINBERGER	DIRECTOR-FIN	ADMIN	11.00%	NONE	6	17.14%	DIR. FEES	2,000	18-3	3
4	GABRIEL WOLFF	DIRECTOR-FIN	ADMIN	10.00%	NONE	45	69.23%	DIR. FEES	2,000	18-3	4
5	KENNETH WEINBERGER	DIRECTOR	ADMIN	3.00%	NONE	2	5.71%	DIR. FEES	1,000	18-3	5
6	SEYMOUR MELNIK	DIRECTOR-PRES	ADMIN	6.05%	NONE	15	42.86%	DIR. FEES	4,800	18-3	6
7	WILLIAM GLICKAUF	DIRECTOR	ADMIN	0	NONE	2	5.71%	DIR. FEES	1,000	18-3	7
8	ARLENE RUBIN	DIRECTOR	ADMIN	8.00%	NONE	3	8.57%	DIR. FEES	1,000	18-3	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,800		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

#	002150

Report Period Beginning:

01/01/01

Ending: 12/31/01

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO X	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$	0.1110	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18 19										18 19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		\$	25
43	IUIALS					Φ	ወ		ም	23

LINCOLN MANOR INC.

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Report Period Beginning:

01/01/01

Ending: 12/31/01

	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code
	Phone Number ()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ŭ	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					 \$	\$		\$	25

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Report Period Beginning:

01/01/01

Ending: 12/31/01

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		8	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13 14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					\$	\$		\$	25

25

25 TOTALS

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	11.1		. 1	V I / 3		,17	11.	·

B. Show the allocation of costs below. If necessary, please attach worksheets.

0021501 Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which	n were derived from allo	cations of central office
or parent organization costs? (See instructions.)		NO

Name of Related Organization **Street Address** City / State / Zip Code Phone Number Fax Number

)	
)	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16 17
17 18										
19										18 19
20										20
21										21
22										22
23										23
2.4										2.4

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$	0.1110	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18 19										18 19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		\$	25
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Report Period Beginning:

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Ending: 12/31/01

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1101010101		= quare 1 000)	1000101105		S	\$	0 11105	S	1
2						-	-			2
3										3
4										4
5										5
6										6
7										7
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11										11
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14										14
15										15
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17									 	17
18									 	18
19									 	19
20									<u> </u>	20 21
21									<u> </u>	
22										22
24										24
	TOTALO					0	0		0	
25	TOTALS					\$	\$		\$	25

LINCOLN MANOR INC.

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Report Period Beginning:

01/01/01

Ending: 12/31/01

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ŭ	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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12										12 13
13 14										13
15										15
16										16
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19										19
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21										21
22										22
23										23
24										24
	TOTALS					\$	\$		\$	25

LINCOLN MANOR INC.

#	0	0	2	1	5	0	1

Report Period Beginning:

01/01/01

Ending: 12/31/01

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		8	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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20										20
21										21
22										22
23										23
24										24
	TOTALS					\$	\$		\$	25

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B. Show the allocation of costs below. If necessary, please attach worksheets.

0021501 Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which we	were derived from allo	cations of central office
or parent organization costs? (See instructions.)	YES	NO

Name of Related Organization **Street Address** City / State / Zip Code Phone Number Fax Number

		I	T		T	T		1	T	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2						•	*		*	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										
24										24
25	TOTALS					 \$	\$		 \$	25

LINCOLN MANOR INC.

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Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII.	ALLC	CATION	OF INDIRECT	COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$	0.1110	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18 19										18 19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		\$	25
23	IUIALS					Ф	D		3	25

LINCOLN MANOR INC.

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related*		rpose of Loan	Monthly Payment	Date of		int of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES N	0		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1	N/A						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related B. Non-Facility Related*	-					s	\$			s	9
	See Supplemental Schedule	$\overline{}$			I							10
11	11											11
12												12
13												13
	TOTAL Non-Facility Related						\$	s			\$	14
15	TOTALS (line 9+line14)						\$	s			\$	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

0021501 Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	6	7	8	9	10	
	Name of Lender	Related	d**	Purpose of Loan	Monthly Payment	Date of	Amo	unt of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
1	N/A						\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9								+				9
10												10
11												11
12												12
14								+				13 14
15												15
16								+				16
17												17
18												18
19												19
20												20
21							\$	\$			\$	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

B. Real Estate Taxes					
1. Deal Estate Townscampel used on 2000 moment		"RE_Tax". The real estate tax statement and		27.276	1
1. Real Estate Tax accrual used on 2000 report.	<u>\$</u>	37,376	1		
2. Real Estate Taxes paid during the year: (Indi-	\$	38,565	2		
3. Under or (over) accrual (line 2 minus line 1).	\$	1,189	3		
4. Real Estate Tax accrual used for 2001 report.	. (Detail and explain your calculation of this accrual on the line	s below.)	\$	38,561	4
**	which has NOT been included in professional fees or other gene h copies of invoices to support the cost and a co	•	\$		5
6. Subtract a refund of real estate taxes. You me classified as a real estate tax cost plus one-hat TOTAL REFUND \$ For each of the state tax cost plus one-had to the state tax cost plus one-had to the state tax cost plus one-had to the state tax cost plus one-had	•	al estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedul	le V, line 33. This should be a combination of lines 3 thru 6.		\$	39,750	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996 32,449 8	FOR OHF USE ONLY			
	1997 35,509 9 1998 36,704 10	13 FROM R. E. TAX STATEMEN	T FOR 2000 \$		13
	1999 36,524 11 2000 38,565 12	14 PLUS APPEAL COST FROM	LINE 5 \$		14
19282.52+19282.52=38565		15 LESS REFUND FROM LINE 6	\$		15
		16 AMOUNT TO USE FOR RATE	CALCULATION \$		10

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

		ГΝ		

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	LINCOLN MAN	OR INC.		COUNTY	MACON
FACILITY IDPH LICE	ENSE NUMBER	0021501			
CONTACT PERSON F	REGARDING TH	IS REPORT Steve Lav	enda		
TELEPHONE (847) 2	36-1111		FAX #: (847) 2	236-1155	
A. Summary of Rea	al Estate Tax Cos	<u>t</u>			
			1		Enter only the portion of the

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> Applicable to
	Tax Index Number	Property Description	Total Tax	Nursing Home
1.	04-30-00-000-009	Long Term Care Property	\$4,042.54_	\$ 4,042.54
2.	04-12-03-251-002	Long Term Care Property	\$ 34,522.50	\$ 34,522.50
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 38,565.04	\$38,565.04_

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? $\underline{\hspace{1cm}}$ YES $\underline{\hspace{1cm}}$ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Page 10A

	lity Name & ID Number LINCOLN MA UILDING AND GENERAL INFORMA			# 0021501 R	Report Period Beginning:	01/01/01 Ending: 12/3	1/01
	Square Feet: 38,340		Exterior B	RICK	Frame	Number of Stories1	<u> </u>
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from a I	Related Organization.		(c) Rent from Completely Unrelated Organization.	
	(Facilities checking (a) or (b) must co	mplete Schedule XI. Those checking (c) may complete Schedule X	II or Schedule XII-A. Se	ee instructions.)		
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipme	ent from a Related Orga	anization.	X (c) Rent equipment from Completely Unrelated Organization.	
	(Facilities checking (a) or (b) must co	mplete Schedule XI-C. Those checking	(c) may complete Schedule	e XI-C or Schedule XII-	B. See instructions.)	g	
Е.	(such as, but not limited to, apartmen	by this operating entity or related to thats, assisted living facilities, day training uare footage, and number of beds/units	g facilities, day care, indepe	endent living facilities, r			
F.	Does this cost report reflect any organ If so, please complete the following:	nization or pre-operating costs which a	re being amortized?		YES	X NO	
1.	. Total Amount Incurred:		2	. Number of Years Over	r Which it is Being Amortiz	zed:	
3.	. Current Period Amortization:		4	. Dates Incurred:			
		Nature of Costs: (Attach a complete schedule det	tailing the total amount of o	organization and pre-op	perating costs.)		
XI. C	OWNERSHIP COSTS:						
	A. Land.	1 Use	2 Square Feet	Voor Agguired	Cost		
	A. Lanu.		Square reet	Year Acquired			
		1 Facility		1973	55,770	1	
		1 Facility 2 Demolished House		1973 \$ 1994	55,770 13,200	1 2	

STATE OF ILLINOIS

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0021501

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number LINCOLN MANOR INC.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	mg Depreciation-Including Fixed Equ	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4				1975	\$ 745,047	\$	35	\$	\$	\$ 745,047	4
5				1981	369,094		35			369,094	5
6				1984	368,408		35			368,408	6
7				1985	5,143		35			5,143	7
8				1993	47,097		35	1,177	1,177	9,662	8
	Impr	ovement Type**									
9	Various			1975	9,508		20	-		7,010	9
	Various			1981	3,615		20	-		3,615	10
	Various			1982	25,660		20	315	315	23,357	11
	Various			1984	2,107		20	-		2,107	12
	Various			1985	13,371		20	-		13,371	13
	Various			1986	12,384		20	438	438	6,798	14
	Various			1987	59,842		20	1,724	1,724	22,412	15
	Various			1988	16,800		20	841	841	4,205	16
	Various			1989	24,981		20	259	259	21,101	17
	Various			1990	26,245		20	68	68	24,269	18
	Various			1991	9,545		20	-	211	9,545	19
	Various			1992	24,119		20	211	211	17,842	20
	Various			1993	9,429		20	391	391	3,565	21
	Various			1994	31,724		20 20	1,039	1,039 3,912	24,102	22
	Various			1995 1996	89,487 96,885		20	3,912 4,846	3,912 4,846	19,915 15,221	24
	Various Various			1997	75,339		20	3,768	3,768	14,608	25
26	various			1777	13,337		20	3,700	3,700	14,000	26
27											27
28								_		_	28
29								_		_	29
30								_		_	30
31								-		_	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								_		-	36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

0021501

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number LINCOLN MANOR INC.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$ -	_	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		•	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48 49					-		-	48 49
50					-		-	50
51					_			51
52					_			52
53					_		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
68 Related Party Allocations (Page 12-REP & Page 12A-REP)		_	_		-		-	67 68
69 Financial Statement Depreciation		_	13,682			(13,682)		69
70 TOTAL (lines 4 thru 69)		\$ 2,065,830	\$ 13,682		\$ 18,989		\$ 1,730,397	70
10 1101AL (mics 7 min u 0)		φ <u>2,003,030</u>	φ 13,002		φ 10,707	φ 3,307	φ 1,750,337	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

Facility Name & ID Number LINCOLN MANOR INC. XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,065,830	\$ 13,682		\$ 18,989	\$ 5,307	\$ 1,730,397	1
2 A/C REPAIR	1998	1,427		20	71	71	178	2
3 FIRE DOORS REPAIR	1998	505		20	25	25	63	3
4 PATCHING DMORT	1998	569		20	28	28	58	4
5 PAINTING	1998	500		20	25	25	52	5
6 WALLS REPAIR	1998	987		20	49	49	102	6
7 KITCHEN FAUCETS	1998	591		20	30	30	88	7
8 COMPRESSOR	1998	1,057		20	53	53	146	8
9 BATHROOM RENOV	1998	582		20	29	29	73	9
10 BATHROOM RENOV	1998	538		20	27	27	63	10
11 FIRE ALARM SYST	1998	21,199		20	1,060	1,060	2,297	11
12 HALL #6-PLUMBING	1998	87,104		20	4,355	4,355	10,888	12
13 SPRINKLER SYSTEM	1998	11,216		20	561	561	1,356	13
14 STEEL DOOR	1998	364		20	18	18	51	14
15 Architects Fees	1998	1,877		20	94	94	243	15
16 DOOR INSTALL	1999	2,475		20	124	124	176	16
17 CLOSET DOORS	1999	11,788		20	589	589	785	17
18 VINYL & BASE	1999	30,429		20	1,521	1,521	1,901	18
19 OXYGEN DOOR	1999	1,603		20	80	80	140	19
20 FOYER COMPLETE	2000	23,424		20	551	551	551	20
21 FIREWALL MECH ROOM	2000	1,420		20	21	21	21	21
22 ROOM RENOVATIONS	2000	4,686		20	100	100	100	22
23 COURTYARD LANDSCAPE	2000	3,922		20	114	114	114	23
24 FRONT BUILDING LANDS	2000	2,484		20	62	62	62	24
25 FOYER BEGIN	2000	20,000		20	470	470	470	25
26 VINYL BASE-HALL 6	2000	6,034		20	151	151	151	26
27 FIRE ALARM SYSTEM	2000	9,649		20	241	241	241	27
28 DOOR ALARM SYSTEM	2000	8,943		20	298	298	298	28
29 VINYL & BASE ROOMS	2000	8,441		20	387	387	387	29
30 FLOORING HALL 1-4	2000	34,632		20	866	866	866	30
31 DOOR KICK PLATES	2000	7,201		20	270	270	270	31
32 CARPET HALL 5	2000	3,894		20	163	163	163	32
33 AIR CLEANER	2000	1,202		20	50	50	50	33
34 TOTAL (lines 1 thru 33)		\$ 2,376,573	\$ 13,682		\$ 31,472	\$ 17,790	\$ 1,752,801	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

Page 12C 12/31/01

Facility Name & ID Number LINCOLN MANOR INC. XI. OWNERSHIP COSTS (continued)

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,376,573	\$ 13,682		\$ 31,472	\$ 17,790	\$ 1,752,801	1
2 TILE HALL 6	2000	12,000		20	450	450	450	2
3 STAFF LOCKERS	2000	1,758		20	44	44	44	3
4 VANITIES	2000	9,772		20	163	163	163	4
5 OUTSIDE SIGN	2000	4,680		20	78	78	78	5
6 SHOWER REPAIR	2000	932		20	35	35	35	6
7 NO EXIT SIGNS	2000	653		20	25	25	25	7
8 PAINTING	2000	2,747		20	80	80	80	8
9 EAST END CONSTRUCTIO	2000	2,402		20	120	120	120	9
10 FIRESTOP	2000	1,479		20	6	6	6	10
11 BATHROOM REMODELING	2001	4,768		20	179	179	179	11
12 WALLPAPER	2001	1,927		20	48	48	48	12
13 PAINTING	2001	16,000		20	133	133	133	13
14 PAINTING	2001	2,828		20	24	24	24	14
15 PAINTING	2001	2,721		20	68	68	68	15
16 VALANCES	2001	7,659		20	32	32	32	16
17 DOORS	2001	1,078		20	23	23	23	17
18 WALL REPAIRS	2001	732		20	3	3	3	18
19 PLUMBING	2001	1,442		20	36	36	36	19
20 HANDRAILS	2001	32,538		20	1,085	1,085	1,085	20
21 STORAGE SHED	2001	7,089		20	148	148	148	21
22 HTG/AC UNIT	2001	4,344		20	127	127	127	22
23 HALL A/C	2001	4,136		20	86	86	86	23
24 REAR DOOR JAM	2001	1,181		20	44	44	44	24
25 CERAMIC TILE	2001	1,670		20	49	49	49	25
26 BLINDS	2001	14,433		20	301	301	301	26
27 CODE ALARM	2001	1,708		20	64	64	64	27
28 VANITIES/FAUCETS	2001	3,785		20	47	47	47	28
29 DOORS/SHELVES/CARPET	2001	11,473		20	478	478	478	29
30 DOOR CLOSURE	2001	1,245		20	57	57	57	30
31 HOT WATER TANK	2001	7,814		20	261	261	261	31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

01/01/01 Ending:

Page 12D 12/31/01

XI. OWNERSHIP COSTS (continued)

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19 20								19
21								21
22								22
23								23
24								24
25								25
26							+	26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number LINCOLN MANOR INC.

B. Building Depreciation-Including Fixed Equipment. (See inst	3	4	5	6	1 7	8	9	\neg
_	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	1
2		2,010,007	10,002		Φ 00,700	22,001	1,787,058	2
3								3
4								4
-								
5								5
6								6
0								/
8 9								8
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

01/01/01 Ending:

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XI. OWNERSHIP COSTS (continued)

1	3	4	5	6	7	8	9	$\overline{1}$
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20 21
21 22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30				†				30
31				†				31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0021501

Report Period Beginning:

01/01/01 Ending:

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XI. OWNERSHIP COSTS (continued)

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15 16
16								17
18								18
19								19
20								20
21								21
22								22
23							†	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		2 42 5 5	12.662			22.00.1	4	33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12H 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See inst	3	4	5	6	1 7	8	9	$\overline{}$
1	Year	•	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward	0011511 1101011	\$ 2,543,567	\$ 13,682	111 1 0 111 0	\$ 35,766	\$ 22,084	\$ 1,757,095	1
2		2,310,307	ψ 10,002		\$ 23,700	\$ 22,001	1,737,055	2
3							1	3
							<u> </u>	4
4								
5								5
6								6
								/
8 9								8
10								10
11								11
12								12
13								13
14								14
15							+	15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24							1	24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

Facility Name & ID Number LINCOLN MANOR INC.

XI. OWNERSHIP COSTS (continued)

R. Building Depreciation-Including Fixed Equipment (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equi	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	1
2		2,810,807	Ψ 10,002		Φ 00,700	22,001	1,767,000	2
3								3
4								4
							1	
5 6								5
7								7
8							1	8
9	-							9
10	+						+	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33 TOTAL (Free 14) 22)		o 2542565	0 12 (02		0 25.566	0 22.004	A 1 757 AAF	33
34 TOTAL (lines 1 thru 33)		\$ 2,543,567	\$ 13,682		\$ 35,766	\$ 22,084	\$ 1,757,095	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including rixed Equi	2	3	4	5	6	7	8	9	
	_	FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4			•		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**									
9	-	••									9
10											10
11											11
12	· · · · · · · · · · · · · · · · · · ·		<u> </u>							· · · · · · · · · · · · · · · · · · ·	12
13											13
14											14
15											15
16											16
17											17 18
18 19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29	<u> </u>										29
30											30
31											31
32											32
33											33
34 35											34 35
36											36
30											30

^{*}Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

0021501

XI. OWNERSHIP COSTS (continued)

1	3	1 4	5	6	7	8	9	\Box
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51 52								51 52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69 50 TOTAL (Constant of Cons		0	0		0	Φ.	0	69
70 TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

LINCOLN MANOR INC.

Report Period Beginning:

01/01/01 **Ending:** 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ĺ	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 244,648	\$ 84,884	\$ 16,182	\$ (68,702)	10	\$ 134,445	71
72	Current Year Purchases	52,943		3,131	3,131	10	3,131	72
73	Fully Depreciated Assets	384,041				10	384,041	73
74								74
75	TOTALS	\$ 681,632	\$ 84,884	\$ 19,313	\$ (65,571)		\$ 521,617	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		CHEVY VAN	1993	\$ 17,701	\$	\$	\$	5	\$ 17,701	76
77										77
78										78
79										79
80	TOTALS			\$ 17,701	\$	\$	\$		\$ 17,701	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,311,870	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,566	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,079	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,487)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L if applicable)	\$ 2,296,413	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

11/7/2005 3:17 PM

This must agree with Schedule V line 30, column 8.

riod Reginning:	01/01/01	E

						,			
Facility Name & I	ID Number	LINCOLN MANOR	R INC.		# 0021501	Report 1	Period Beginn	ing: 01/01/01	Ending:
 Name of Does the 	and Fixed Equipme Party Holding Leas			al amount shown below on		NO			
	1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*			
Original 3 Building:	Constructed	of Beds	Deuse	\$	of Ecuse	renewar option	3	0. Effective dates of curre Beginning	nt rental agreeme
4 Additions 5							5	Ending	
6 7 TOTAL				\$			6 1 7	1. Rent to be paid in futur rental agreement:	e years under the
		ation of lease expense by dividing the total						Fiscal Year Ending	Annual Rent

J. Effective (lates of current	rental agreement:
Beginning		
Ending		<u> </u>
O		

rs under the current

1.1	scar rear Ending	Annual Kent	
12.	/2002	\$	
13.	/2003	\$	
14.	/2004	\$	

- 9. Option to Buy: YES NO Terms:
- B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.) 15. Is Movable equipment rental included in building rental?

YES X NO

Description: DISHWASHER-\$2411, ICE MACHINE-\$1485, HOBART DW-\$510 16. Rental Amount for movable equipment: \$

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

by the length of the lease

	1	2	3	4	
		Model Year	Monthly Lease	Rental Expense	
	Use	and Make	Payment	for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

- * If there is an option to buy the building, please provide complete details on attached schedule.
- ** This amount plus any amortization of lease expense must agree with page 4, line 34.

			S	TATE OF ILLIN	OIS					Page 15
		N MANOR INC.			# 00	021501	Report Period Beginning:	01/01/01	Ending:	12/31/01
XIII. EXPEN	SES RELATING TO NURSE AIDE	TRAINING PROGRAMS (See	instructions.)							
A. TYPI	E OF TRAINING PROGRAM (If aid	es are trained in another facility	y program, attach a s	schedule listing th	e facility nar	ne, address	and cost per aide trained in th	at facility.)		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT		YES	2. CLASSROOM	PORTION:	<u> </u>		3. CLINICAL PO	RTION:	<u> </u>	
	DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was	X NO	IN-HOUSE PR	OGRAM			IN-HOUSE PRO	OGRAM		
	of this schedule. If "no", provide an		IN OTHER FA	CILITY			IN OTHER FAC	CILITY		
			COMMUNITY	COLLEGE			HOURS PER A	IDE		
	not necessary.	. ••	HOURS PER A	AIDE						
B. EXPI	ENSES		ELON OF COSTS	(1)			C. CONTRACTUAL IN	COME		
		ALLOCAT	TION OF COSTS	(d)			In the hear heles		a	
		1	2	3		4	In the box belov facility received			•
			acility				-		7	
1 0	'. C. II. T. '.'	Drop-outs	Completed	Contract	T	otal	<u> </u> \$			
I I ICo	mmunity College Tuition	18	18	IS	18					

			T a	Chity		
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		\$	\$	\$	\$
2	Books and Supplies					
3	Classroom Wages	(a)				
	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2	(e)	\$		_	

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

D. NUMBER OF AIDES TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(STECIAL SERVICES (Direct Cost) (S	1	2	3	4	5	6	7	8	
		Schedule V Staff		f Outside Practitioner		e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	an consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3+5+6$)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			9,771					9,771	13
14	TOTAL			\$ 9,771		\$	\$		\$ 9,771	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LINCOLN MANOR INC. XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

	This report must be completed even	1	ianciai stateme	2 After	
		C	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	74,637	\$	1
2	Cash-Patient Deposits		3,925		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		410,574		3
4	Supply Inventory (priced at)		2,748		4
5	Short-Term Investments		123,938		5
6	Prepaid Insurance		11,634		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify): See supplemental schedule		1,900		9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	629,356	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		84,560		13
14	Buildings, at Historical Cost		1,898,651		14
15	Leasehold Improvements, at Historical Cost		25,033		15
16	Equipment, at Historical Cost		1,081,079		16
17	Accumulated Depreciation (book methods)		(2,433,264)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): See supplemental schedule				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	656,059	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	1,285,415	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	82,862	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		3,925		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		58,673		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		1,039		31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,561		32
33	Accrued Interest Payable				33
34	Deferred Compensation		131,800		34
35	Federal and State Income Taxes		11,231		35
	Other Current Liabilities(specify):				
36	See supplemental schedule		16,215		36
37	•				37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	344,306	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	See supplemental schedule				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	344,306	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	941,109	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	Y \$	1,285,415	\$	48

*(See instructions.)

Ending: 12

Total 828,890 Balance at Beginning of Year, as Previously Reported Restatements (describe): 2 3 3 4 4 5 Balance at Beginning of Year, as Restated (sum of lines 1-5) 828,890 6 A. Additions (deductions): 7 NET Income (Loss) (from page 19, line 43) 712,219 Aguisitions of Pooled Companies 8 Proceeds from Sale of Stock 9 10 Stock Options Exercised 10 11 11 Contributions and Grants 12 12 Expenditures for Specific Purposes 13 Dividends Paid or Other Distributions to Owners (600,000)13 14 14 Donated Property, Plant, and Equipment 15 Other (describe) 15 16 Other (describe) 16 17 17 TOTAL Additions (deductions) (sum of lines 7-16) 112,219 B. Transfers (Itemize): 18 18 19 19 20 20 21 22 **TOTAL Transfers (sum of lines 18-22)** 23 24 24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) 941,109

^{*} This must agree with page 17, line 47.

Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

			1	
	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	4,052,360	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	4,052,360	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		7,844	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	7,844	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See supplemental schedule		254	28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	254	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	4,060,458	30

			L	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		974,155	31
32	Health Care		1,458,672	32
33	General Administration		685,304	33
	B. Capital Expense			
34	Ownership		142,721	34
	C. Ancillary Expense			
35	Special Cost Centers		10,737	35
36	Provider Participation Fee		76,650	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	3,348,239	40
	`	i		i
41	Income before Income Taxes (line 30 minus line 40)**		712,219	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	712,219	43

- This must agree with page 4, line 45, column 4.
- Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.
- See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number LINCOLN MANOR INC.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

	(This schedule must cover th	e entire reportin	g period.)	• • • •		
	•	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,895	2,142	\$ 52,153	\$ 24.34	1
2	Assistant Director of Nursing	3,856	4,285	81,245	18.96	2
3	Registered Nurses	7,386	7,648	131,168	17.15	3
4	Licensed Practical Nurses	23,959	24,709	331,366	13.41	4
5	Nurse Aides & Orderlies	63,663	65,064	626,719	9.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	326	326	9,771	29.97	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	2,142	30,299	14.14	9
10	Activity Assistants	5,247	5,741	66,704	11.62	10
11	Social Service Workers	4,960	5,288	34,486	6.52	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,142	31,986	14.93	13
	Head Cook					14
15	Cook Helpers/Assistants	28,255	25,982	202,248	7.78	15
16	Dishwashers					16
17	Maintenance Workers	3,799	4,252	52,222	12.28	17
	Housekeepers	24,090	25,132	148,458	5.91	18
19	Laundry	9,160	9,440	67,173	7.12	19
20	Administrator	2,396	2,142	100,000	46.68	20
21	Assistant Administrator					21
22	Other Administrative					22

6,026

1,870

190,627

6,427

2,142

195,005

23 Office Manager

27 Medical Director

31 Medical Records

33 Other(specify)

25 Vocational Instruction

26 Academic Instruction

28 Qualified MR Prof. (QMRP)

29 Resident Services Coordinator

30 Habilitation Aides (DD Homes)

32 Other Health Care(specify)

TOTAL (lines 1 - 33)

24 Clerical

2,041,784

23,269

52,517

B. CONSULTANT SERVICES

2, 0	01,002111,10211,1020	1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	341	\$ 15,356	01-03	35
36	Medical Director	96	13,950	09-03	36
37	Medical Records Consultant	124	12,975	10-03	37
38	Nurse Consultant	111	8,649	10-03	38
39	Pharmacist Consultant	96	600	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	100	10a-03	43
44	Activity Consultant	109	4,660	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	PODIATRY CONSULTANT	60	1,850	10-03	47
48	DERMATOLOGICAL CONSULTAN	48	3,500	10-03	48
40	TOTAL (1: az 25 49)	006	6 (1 (40		40
49	TOTAL (lines 35 - 48)	986	\$ 61,640		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

23

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34

8.17

10.86

10.47

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

						ATE OF ILLINOIS				rage	
	LINCOLN MANOR	INC.			#_ 00	21501	Repo	ort Period Beg	inning: 01/01/01 End	ing:	12/31/01
XIX. SUPPORT SCHEDULES						D. H.W.					
A. Administrative Salaries		Ownership	þ		D. Employee Benefits and				F. Dues, Fees, Subscriptions and Promo	tions	
Name	Function	%	_	Amount		cription	_	Amount	Description		Amount
SHEILA MCCLUNG	ADMINISTRATOR		. \$_	100,000	Workers' Compensation 1		_ \$_	40,548	IDPH License Fee	\$	200
			_		Unemployment Compens	ation Insurance		14,192	Advertising: Employee Recruitment		2,256
					FICA Taxes			145,737	Health Care Worker Background Chec		204
					Employee Health Insuran	ce		118,283	(Indicate # of checks performed 17	<u> </u>	
			_		Employee Meals		_		ADVERTISING		663
					Illinois Municipal Retiren	nent Fund (IMRF)*	_		SUBSCRIPTION		253
			· ' <u>-</u>		OTHER EMPLOYEE BE	NEFITS		5,401	DUES		465
TOTAL (agree to Schedule V, line	17, col. 1)		_						PERMITS		425
(List each licensed administrator s	separately.)		\$	100,000			_		YELLOW PAGE		903
B. Administrative - Other	<u> </u>						_		PUBLIC RELATIONS		4,050
									Less: Public Relations Expense		(4,050)
Description				Amount					Non-allowable advertising		(663
Description			\$	1 mount					Yellow page advertising		(903
			Ψ_						Tenow page advertising		(>00
			-		TOTAL (agree to Schedu	ıle V	2	324,161	TOTAL (agree to Sch. V,	•	3,803
			_		line 22, col.8)	iic v,	Ψ=	324,101	line 20, col. 8)	9 =	3,003
TOTAL (agree to Schedule V, line	17 col 3)		•		E. Schedule of Non-Cash	Compansation Paid			G. Schedule of Travel and Seminar**		
,	,		ψ ₌			•			G. Schedule of Travel and Seminal		
(Attach a copy of any managemen	t service agreement)				to Owners or Employe	es			D		
C. Professional Services	TD.				1 5	T • "			Description		Amount
Vendor/Payee	Type		_	Amount	Description	Line #		Amount			
MCGUIRE, YUHAS	ACCOUNTING		. \$_	14,446		<u> </u>	_ \$_		Out-of-State Travel	\$_	
FR&R	ACCOUNTING			12,755							
ENLOES	COMPUTER		_	2,300			_				
WINTERS, FEATHERSTON	LEGAL			11,033					In-State Travel		664
SACHNOFF & WEAVER	LEGAL			251			_				
ARCHITCTURAL EXPRESS.	ARCH-LIFE SA	FETY	_	225			_				
			_								
			_				_		Seminar Expense		4,183
			_					_	1		· · · · · · · · · · · · · · · · · · ·
			-								
			-	•				_			
			_						Entertainment Expense		
TOTAL (agree to Schedule V, line	19 column 3)		-		TOTAL		\$		(agree to Sch. V,		
(If total legal fees exceed \$2500 att		`	•	41,010	IVIAL		Ψ=		TOTAL line 24, col. 8)	\$	4,847
(11 total legal lees exceed \$2500 att	ach copy of invoices.)	Þ	41,010	411.50				I O I AL IIIIe 24, coi. o)	Þ	4,04 /

^{*} Attach copy of IMRF notifications

TOTALS

Report Period Beginning: 01/01/01 Ending:

Page 22

12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.) 1 3 5 6 8 9 10 11 12 13 2 Month & Year **Amount of Expense Amortized Per Year Improvement Improvement Total Cost** Useful **Was Made** FY1998 FY1999 FY2000 FY2001 FY2002 FY2003 FY2004 FY2005 Type Life FY2006 1 N/A \$ \$ 3 5 6 8 9 10 11 12 13 14 15 16 17 18 19